Student Name ☐ Male ☐ Female	Meeting Date	Purpose of Meeting ☐ Initial Eligibility, IEP, Placement ☐ Annual Review of IEP ☐ Three Year Reevaluation ☐ Dismissal from Services Date: _____ ☐ Parent Request ☐ Other: _____
Social Security Number	Age Grade	
Date of Birth	Date Services Begin	Discussed evaluation results/progress/assessment method ☐ Yes ____ (Parent/Guardian initial) Copy of evaluation results received ☐ Yes ____ (Parent initial)
School of Residence	Annual Review Date	***Transition Planning Needed ☐ No** **☐ Yes (If yes, attach applicable transition pages.)**
Attendance Center	Parent/Guardian Name, Address, Phone	Student is eligible for special education or special education and related services as determined by the IEP team ☐ Yes ☐ No
Date of Multidisciplinary Evaluation	Hm: Wk:	An annual copy of Parent/Guardian Rights was received and reviewed _____(Date) _____ (Parent/Guardian Initial)
Three Year Reevaluation Due	Parent/Guardian Name, Address, Phone Hm: Wk:	A copy of the IEP was provided to parent/guardian ☐ Yes _____ (Parent/Guardian Initial)

IEP Team Membership		Signature		Date
Parent/Guardian				
Parent/Guardian				
Student				
Superintendent/Designee				
General Classroom Teacher				
Special Education Teacher				
Speech/language Pathologist				
Evaluator				
Title				
Title				
Title				

Child Count Information (District Option to Complete)

Disabling Condition

☐ 0500 ☐ 0505 ☐ 0510 ☐ 0515 ☐ 0525 ☐ 0530 ☐ 0535
☐ 0540 ☐ 0545 ☐ 0550 ☐ 0555 ☐ 0560 ☐ 0555 ☐ 0570

Ethnicity _____
W B I H A O

A. Minutes per week in Special Education _____

B. Minutes per week in Related Services	**Minutes**	**Services**
	_____	_____
	_____	_____
	_____	_____

C. **A + B = (Total minutes of Special Education/Related Services)** _____

Placement

☐ 0100 Regular Classroom with Modification
☐ 0110 Resource Room
☐ 0120 Self-Contained Classroom
☐ 0130 Day Program Code: _____
☐ 0140 24 Hour Program Code: _____
☐ 0150 Home/Hospital
☐ 0305 Home
☐ 0315 Early Childhood Setting
☐ 0325 Part-Time Early Childhood/Part-Time Early Child Special Education Setting
☐ 0335 Early Childhood Special Education Setting
☐ 0345 Separate School
☐ 0355 Residential Facility

Parent/Guardian declines all special education services

Parent/Guardian Signature: _____

Individual Education Program

Student Name ☐ Male ☐ Female	Meeting Date	Purpose of Meeting ☐ Initial Eligibility, IEP, Placement ☐ Annual Review of IEP ☐ Three Year Reevaluation ☐ Dismissal from Services Date: _____ ☐ Parent Request ☐ Other: _____
Social Security Number	Age Grade	
Date of Birth	Date Services Begin	Discussed evaluation results/progress/assessment method ☐ Yes ____ (Parent/Guardian initial) Copy of evaluation results received ☐ Yes ____ (Parent initial)
School of Residence	Annual Review Date	***Transition Planning Needed ☐ No** **☐ Yes (If yes, attach applicable transition pages.)**
Attendance Center	Parent/Guardian Name, Address, Phone Hm: Wk:	Student is eligible for special education or special education and related services as determined by the IEP team ☐ Yes ☐ No An annual copy of Parent/Guardian Rights was received and reviewed _____(Date) _____ (Parent/Guardian Initial)
Date of Multidisciplinary Evaluation		
Three Year Reevaluation Due	Parent/Guardian Name, Address, Phone Hm: Wk:	A copy of the IEP was provided to parent/guardian ☐ Yes _____ (Parent/Guardian Initial)

IEP Team Membership	Signature	Date
Parent/Guardian		
Parent/Guardian		
Student		
Superintendent/Designee		
General Classroom Teacher		
Special Education Teacher		
Speech/language Pathologist		
Evaluator		
Title		
Title		
Title		
Title		
Title		
Title		
Title		
Title		

Parent/Guardian declines all special education services

Parent/Guardian Signature: _____

Based on evaluation, include academic achievement and functional performance (strengths and weaknesses) in the areas affected by the student's disability, including transition in the IEP to be in effect when the student turns 16; parent concerns; and how the student's disability affects the student's involvement and progress in the general education curriculum. (For a preschool child, how the disability affects his/her participation in appropriate activities.)

Student Name:	**IEP Date:**

Is the student limited English proficient? ☐ Yes ☐ No
If the answer to this question is "yes", please explain the language needs of the student as these needs relate to the student's IEP.

_____
_____
_____

Are there any special communication needs? ☐ Yes ☐ No
If the answer to this question is "yes", what direct instruction will be provided in the student's mode of communication?

_____
_____
_____

Does the student require Braille? ☐ Yes ☐ No
If the answer to this question is "yes", what Braille services will be provided?

_____
_____
_____

Does the student's behavior impede his or her learning or that of others? ☐ Yes ☐ No
If yes, what strategies are required to appropriately address this behavior, including positive behavioral interventions and supports?

_____
_____
_____
_____
_____
_____
_____
_____
_____

Assessment **State and/or District-wide** **(Circle the form(s) of assessment that student will take.)**

1. ☐ Student will be taking the assessment without accommodations. (This student will only need annual goals)

2. ☐ Student will be taking the assessment with the accommodations identified on Page 6. (This student will only need annual goals)

3. ☐ Student will be taking an alternate assessment (The alternate assessment is for students working in the alternate achievement standards)

a. Explain the reason why the student cannot participate in the regular assessment. _____
_____
_____
_____

b. Explain the reason why the alternate assessment selected is appropriate for this student_____
_____
_____

4. ☐ Student not required to take district or statewide assessment at this grade level.

Life Planning Outcomes: (Required on or before the student's 16th birthday)

Employment: _____

_____

Living: _____

_____

Transition Course of Study Related to Life Planning Outcomes (Required on or before the student's 16th birthday)

8th Grade	9th Grade	10th Grade	11th Grade	12th Grade

Comments: _____

_____

Transfer of Parent/Guardian Rights (Must be addressed on or before the 17th birthday).

Student will turn 17 on _____. Student was informed of this transfer of rights on _____/_____/_____.

Graduation or Completion of an Approved Program (Must be addressed at least one year prior to graduation date.)

Student is to graduate/complete program: (Date) _____/_____/_____

Individualized district specific requirements needed to complete an approved secondary education program: _____

_____

Post-Graduation Summary:

Academic Achievement: _____

_____

_____

Functional Performance: _____

_____

_____

Post secondary/Adult Service Recommendations: _____

_____

_____

*Transition Service/Activity Areas including assessments to be covered in this plan. (Required on or before student's 16th birthday)

Employment: (See goal(s) #_____)

Activity Recommendations	Title of Personnel/Agency Responsible	Date Initiated	Projected Date Completed	Date Completed

Independent Living: (See goal(s) #_____)

Activity Recommendations	Title of Personnel/Agency Responsible	Date Initiated	Projected Date Completed	Date Completed

Community Participation: (See goal(s) #_____)

Activity Recommendations	Title of Personnel/Agency Responsible	Date Initiated	Projected Date Completed	Date Completed

Adult Services: (See goal(s) #_____)

Activity Recommendations	Title of Personnel/Agency Responsible	Date Initiated	Projected Date Completed	Date Completed

Post Secondary Education: (See goal(s) #_____)

Activity Recommendations	Title of Personnel/Agency Responsible	Date Initiated	Projected Date Completed	Date Completed

Student Name	**Title of personnel responsible**	
Measurable Annual Goal#__	**Procedure Code**	**Progress Code & Date**

Objective/Benchmark **(Only required for students who take alternate assessments aligned to alternate achievement standards)**

Objective/Benchmark **(Only required for students who take alternate assessments aligned to alternate achievement standards)**

Objective/Benchmark **(Only required for students who take alternate assessments aligned to alternate achievement standards)**

Procedure Codes
(Complete at IEP meeting)

1 Teacher-made tests
2 Observations
3 Weekly tests
4 Unit tests
5 Student Conferences
6 Other: _____
7 Work Samples
8 Portfolios
9 Oral Tests
10 Data Response

Progress Codes

P = Progress being made
I = Insufficient Progress to meet goal
X = Not Addressed this Reporting Period
M=Met goal

Reporting Frequency to Parents

☐ Quarterly Reports
☐ Other Describe frequency _____

Reporting Method to Parents

☐ Conferences
☐ Report Card
☐ Copy of Goal Page
☐ Other _____

*** See modifications checklist for specific goal modifications**

Modifications and Supplemental Aids/Services or Supports for Student and/or School Personnel

Student Name _____

Describe accommodations/program modifications and frequency of these modifications/program modifications to be used in general and special education, including supplemental aids/services or supports for school personnel, that will be provided to the student.

All Areas (unless otherwise specified)	English/Language Arts	Mathematics	Science	Social Studies	Health	Fine Arts	PE/Athletics	Reading	Related Services	Goal(s) #	Goal(s) #	Other:	State or district		Frequency			
															Daily	Weekly	Monthly	Other:
														1. Small group instruction				
														2. Guided to unguided instruction				
														3. Taped texts				
														4. Highlighted texts				
														5. Taping lectures				
														6. Note taking assistance				
														7. Extended time for assignment completion				
														8. Shortened assignments				
														9. Assignment notebooks				
														10. Peer tutoring				
														11. Study guides				
														12. Repeated review/drill				
														13. Preferential seating				
														14. Frequent breaks				
														15. Concrete/positive reinforcers				
														16. Special instructional/adaptive equipment				
														17. Increased verbal response time				
														18. Directions given in a variety of ways (Specify)				
														19. Alternative materials (Specify)				
														20. Adjustments for speech intelligibility/fluency				
														21. Alternative setting				
														22. Oral tests				
														23. Short answer tests				
														24. Extended time for test completion				
														25. Taped tests				
														26. Multiple test sessions				
														27. Other:				
														28. Other:				
														29. Other:				
														Supports For School Personnel				
														30. Consultant service (Specify)				
														31. Specialized material (Specify)				
														32. Other:				

Related Services To Be Provided

	Title of Personnel Responsible	Description	Amount of Services, and Location
☐ **A. Occupational Therapy**			
☐ **B. Physical Therapy**			
☐ **C. Psychological Services**			
☐ **D. Counseling Services**			
☐ **E. Social Work Services**			
☐ **F. Audiological Services**			
☐ **G. Recreation Therapy**			
☐ **H. School Nurse Services**			
☐ **I. Speech/Language Therapy**			
☐ **J. Transportation** (Specify when, how often, where, distance, costs, etc.)			
☐ **K. Other**			
☐ **L. Assistive Technology**			
☐ **M. Orientation and Mobility**			
☐ **N. Medical Services (**Diagnostic Services only)			
☐ **O. Interpreting Services**			
☐ **P. Parental Counseling/Training**			

Physical Education

☐ Regular ☐ Not Required ☐ Adaptive Physical Education (Short-Term Objectives attached)

Hearing Aid Maintenance If yes, Title of Personnel Responsible for Monitoring _____

Monitoring Frequency _____

☐ Yes ☐ Not Applicable Monitoring Process _____

_____

Continuum of Alternative Placements

- ☐ 0100 General Classroom with Modifications 80-100%
- ☐ 0110 Resource Room 40-79%
- ☐ 0120 Self-Contained Classroom 0-39%
- ☐ 0130 Day Program> 50% out of home school
- ☐ 0140 24 Hour Program
- ☐ 0150 Home/Hospital

Special Education to be provided: (Specify description of services, amount of services, and location of services)

Comments:

Participation with Non-Disabled Peers

☐ General Classroom With Modifications (student is in regular classroom 80% of the time or more)
*If this box is checked, do not complete the following boxes in this section.

Program Options

- ☐ Art
- ☐ Industrial Technology
- ☐ Music
- ☐ Vocational Education
- ☐ Home Economics
- ☐ Other _____

Comments:

Non-Academic

- ☐ Counseling
- ☐ Meals
- ☐ Employment Referrals
- ☐ Recess
- ☐ Health
- ☐ Other _____

Comments:

Extracurricular

- ☐ Athletics
- ☐ Clubs
- ☐ Groups
- ☐ Recreation
- ☐ Other _____

Comments:

Justification for Placement--An explanation of the extent, if any, to which the child will not participate with non-disabled children in the regular class, and in extracurricular and non-academic activities. (Please use accept/reject format for each alternative placement considered.)

☐ The team addressed the potential harmful effects of the special education placement.

Reintegration Plan

Is the student moving from a more to less restrictive environment? ☐ Yes ☐ No
If yes, what strategies are required to appropriately address reintegration?

_____

_____

_____

_____

_____

_____

_____

Continuum of Alternative Placements	***Special Education to be provided: (Specify description of services, amount of services, and location of services)***
☐ *0305 Home* ☐ *0315 Early Childhood Setting* ☐ *0325 Part-Time Early Childhood/Part-Time Early Childhood Special Education Setting* ☐ *0335 Early Childhood Special Education Setting* ☐ *0345 Separate School* ☐ *0355 Residential Facility*	***Comments:***

Does child attend a regular education program? Yes ☐ ***No*** ☐
(District-run preschool, Head Start, Kindergarten)
If yes, please provide a description:

Justification for Placement--An explanation of the extent, if any, to which the child will not participate with non-disabled children in regular classes, and non-academic activities. (Please use accept/reject format for each alternative placement considered.)

☐ *The team addressed the potential harmful effects of the special education placement.*

Reintegration Plan
Is the student moving from a more to less restrictive environment? ☐ *Yes* ☐ *No*
If yes, what strategies are required to appropriately address reintegration?

Extended School Year Services: ☐ needed ☐ not needed ☐ to be determined by (Date) _____/_____/_____

Goal(s) #	*Type of Service	Beginning Date mm/dd/yy	Ending Date mm/dd/yy	Minutes Per Week	Based on **

* Instruction, related services (specify), other (list)

** Regression/Recoupment, Emerging Skills, or Maintenance of Critical Life Skills

Parent/Guardian Consent For Extended School Year Program only

"Consent" means that the parent(s)/guardian(s) have been fully informed of all information relevant to the activity for which consent is sought, in the native language, or other mode of communication; the parent(s)/guardian(s) understand and agree in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists any records which will be released and to whom; and the granting of consent by the parent(s)/guardian(s) is voluntary and may be revoked in writing at any time.

_____ _____

Parent/Guardian Signature Date

Parent/Guardian Consent Required For Initial Placement Only

"Consent" means that the parent(s)/guardian(s) have been fully informed of all information relevant to the activity for which consent is sought, in the native language, or other mode of communication; the parent(s)/guardian(s) understand and agree in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists any records which will be released and to whom; and the granting of consent by the parent(s)/guardian(s) is voluntary and may be revoked in writing at any time.

_____ _____

Parent/Guardian Signature Date

Clarifying Comments:

Individual Education Plan Addendum
Addendum to IEP dated _____/_____/_____

Student Name	Meeting Date	Date of Birth

Purpose of Meeting
☐ Parent Request
☐ Other (Please specify):

A copy of this IEP addendum was provided to parent/guardian
☐ Yes ___ (Parent/Guardian Initial)

IEP Team Membership	Signatures	Date
Parent/Guardian		
Parent/Guardian		
Student		
Superintendent/Designee		
General Classroom Teacher		
Special Education Teacher		
Speech/Language Pathologist		
Evaluator		
Title		
Title		
Title		

Child Count Information (District Option to Complete)
Disabling Condition
☐ 0500 ☐ 0505 ☐ 0510 ☐ 0515 ☐ 0525 ☐ 0530 ☐ 0535
☐ 0540 ☐ 0545 ☐ 0550 ☐ 0555 ☐ 0560 ☐ 0555 ☐ 0570

Ethnicity _____
W B I H A O

A. Minutes per week in Special Education _____
B. Minutes per week in Related Services

Minutes	**Services**
_____	_____
_____	_____
_____	_____

C. **A + B = (Total minutes of Special Education/Related Services)** _____

Placement

☐ 0100 Regular Classroom with Modification
☐ 0110 Resource Room
☐ 0120 Self-Contained Classroom
☐ 0130 Day Program Code: _____
☐ 0140 24 Hour Program Code: _____
☐ 0150 Home/Hospital
☐ 0305 Home
☐ 0315 Early Childhood Setting
☐ 0325 Part-Time Early Childhood/Part-Time Early Child Special Education Setting
☐ 0335 Early Childhood Special Education Setting
☐ 0345 Separate School
☐ 0355 Residential Facility

Meeting Notes

IEP Addendum (Continued)

Student Name:	Meeting Date: